




Lessons Learned from a CAH Hospital Information System Upgrade

Optimizing the use of technology within the revenue cycle has been a topic of interest for hospital leaders for some time. Some hospitals may need to upgrade major information systems to take advantage of next generation functionalities that can streamline clinical and financial processes. Other organizations may be motivated by subsidies from the federal government that are available for healthcare providers



Monadnock Community Hospital
Peterborough, New Hampshire

🏠 **Bed Size: 25**

💰 **Net Patient Revenue: Approximately \$66 million**

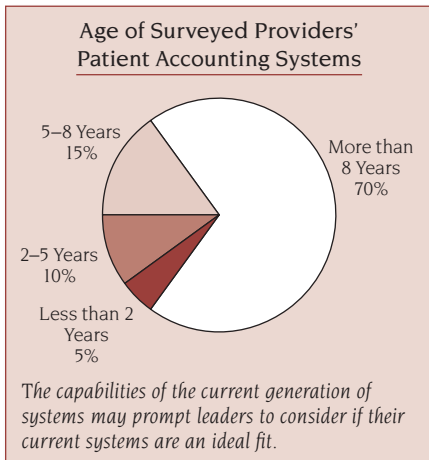
who demonstrate meaningful use of new information systems. Regardless of motivation, a major system upgrade at any organization requires thorough project planning and cooperation to be executed successfully.

Critical access hospitals face some unique challenges when embarking on a system conversion. With fewer staff and IT resources than larger organizations, CAH's must be prudent about how they delegate responsibilities during a major technology upgrade. For insight into how one CAH managed its recent system conversion, The Academy spoke with leaders at Monadnock Community Hospital (MCH), a 25-bed facility located in Peterborough,

New Hampshire.

Rich Scheinblum, Chief Financial Officer, says several factors led MCH to undertake a system conversion. At the time, MCH was changing its designation to critical access from provider based, and enlisted its current system vendor to provide guidance. "There were some changes we were going through, and we decided [the previous system] wouldn't be a good fit for us anymore," Scheinblum explains. "We still wanted a best in breed system from a reputable vendor. Because of the time frame we had to do a conversion in, we decided Paragon® [Mckesson's CAH-specific product] would be the best fit for us." In

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Applying Lean and Six Sigma Methodologies

Organizations of all sizes have utilized Lean and Six Sigma to strategically improve efficiency and resource allocation. By providing training and engaging team members in focused improvement efforts, CAHs can work to maximize operating efficiency and net revenue—thereby ensuring resources are available to provide essential patient care. The Academy recently spoke with leaders of two critical access facilities to learn more about applying these quality improvement methodologies.

Identifying a Strategy to Guide Process Improvements

Garfield County Hospital (GCH) in Pomeroy, Washington created an organizational culture centered on Lean principles to drive

process improvements. Before seeking community support for a bond measure to renovate the facility, GCH needed to analyze existing workflows and determine how the patient experience could be enhanced through redesign. Participation in quality workshops had exposed the organization to Lean and rapid cycle improvement techniques.

"Once we identified what [operational] areas we needed to focus on, what our objectives were, and what kind of outcomes we [were] seeking to achieve, we needed a vehicle to improve those processes and achieve standardization and consistent outcomes," explains Andrew Craigie, Garfield's CEO. Ultimately, the hospital developed a quality improvement

process that integrated multiple strategies—Baldrige Criteria for systems-level planning, the Chronic Care Model for deploying operational strategies, and Lean for process improvements.

To provide Lean training, GCH engaged an external business partner. The management team participated in a process walk to understand patient movement through the facility and developed a model for the ideal patient experience. "It was a good way to introduce the concepts of Lean to our management team," Craigie recalls. "Not only to crack that nut, but also to teach Lean to our management team so we could continue to improve work processes in other areas of the organization."

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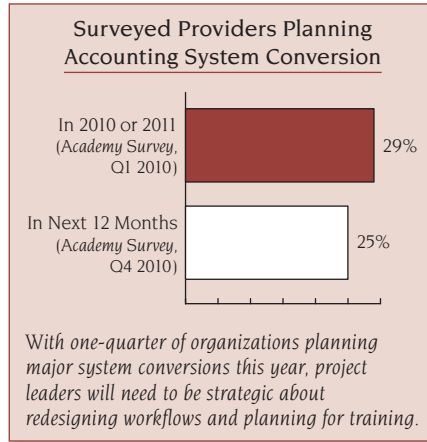
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addition, MCH leaders felt the new system would offer flexibility in terms of adopting an integrated health record and demonstrating meaningful use.

Once a system was identified, careful design of the new system's structure and a thorough testing process were critical to a smooth conversion. Janet Willis, Director of Patient Financial Services, had gone through a system conversion before, and applied her previous experience to this upgrade. "In our structure here, we had what we called subject matter experts," Willis says. "SME's were hospital staff members who were actually doing the build, but then also involved in training and the integrated testing. Using SME's was the biggest thing that made the implementation successful."

MCH also created an EHR functional team, which was a multi-disciplinary group of about 25 hospital team members that met weekly to assess the progress of the upgrade. This group was divided into different functional teams that would be affected by the conversion—such as financial, scheduling, order management, and registration.

Each functional team had a leader, who was responsible for establishing and maintaining the scope of their module, identifying and escalating major issues, managing resources, and ensuring completion of project tasks on or before the due date. The SME's (also called "super users") were responsible for attending all scheduled visits, participation in testing, process documentation and design, and training end users. In addition to the team leader and SME's, other staff members participated in completion team meetings, providing knowledge and support for completion of project tasks.



For an example of how this worked in practice, Willis and MCH's accounting manager led the financial team, which designed the system's registration and patient financial service functions. Under them were the super users (SME's) that designed the new processes and also helped create training manuals for their respective areas—for example, the registration supervisor was an SME and developed the registrar manual. Since MCH already used an accounting system by the same vendor, staff were comfortable with many of the new system's functions, but they would have to learn new tasks such as creating an invoice, setting up pre-bill edits, and creating batches. Once the project reached the testing phase, SME's pulled screen captures of the new system to complete the training manuals. Classroom instruction was conducted for six weeks prior to conversions—far enough in advance to be comprehensive and effective, but not so far that users would forget what they learned.


MCH's integrated testing plan involved running scenarios for various patient types—inpatient, observation, ED, ancillary, recurring—from the time the patient presented until the account passed cleanly through the hospital's claim scrubber.

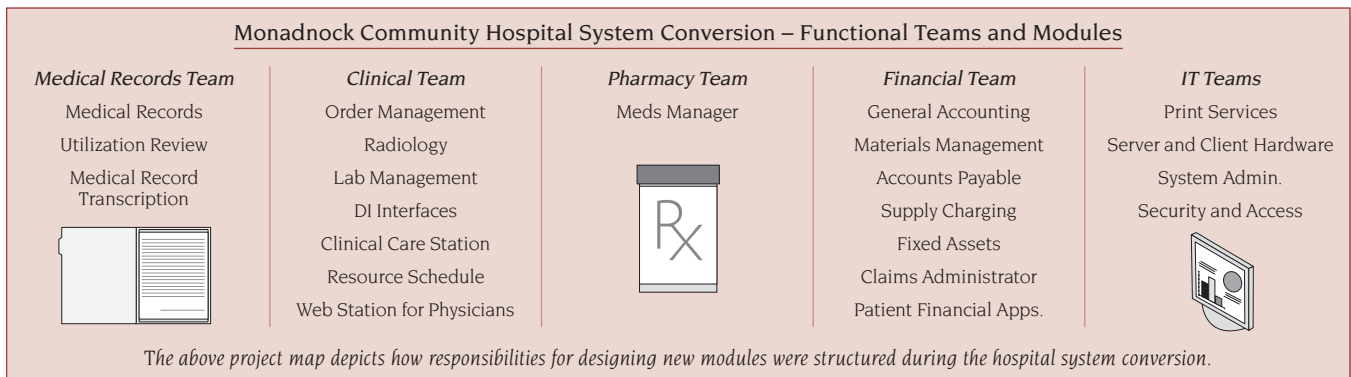
The testing phase included 20–25 different patient scenarios and took about three months to complete.

Another key component of MCH's system upgrade was the direct conversion of all bad debt and A/R from the previous system. According to Willis, her previous system conversion experience did not include bad debt, which in retrospect was a regrettable decision. By doing a bad debt conversion this time, MCH was better able to manage accounts with its collection agencies because payments posted can be sent from the system to the agencies. In addition, direct conversion of A/R meant staff had to use the new system right away, immediately building their understanding and familiarity with it.

Although the current system has been in place for over three years, the EHR functional team and SME roles are still in place to address system upgrades and plan for additional functionalities. Having this implementation framework established and prepared to oversee future technology implementations is especially important for a CAH with limited resources.

"From a CAH perspective, we have to take on a lot, we don't have a giant IT department," says Willis. "So I think the creation of our internal EHR group and having SME's for each area was key, because we were able to build that internal knowledge and didn't have to seek outside support."

Although the relatively small size of CAH's means staff members have to assume greater roles in facilitating the implementation of new technology, an effective project planning structure can support successful upgrades. By leveraging the expertise of super users to direct all phases of a system conversion project, CAH's can meet the challenges posed by major technology upgrades with minimal disruption. 



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Fostering an Organization-Wide Commitment to Improvement

Since then, GCH has worked to optimize numerous sub-processes—for example, quality and governance—in addition to using Lean in clinical departments. Sub-process leaders, typically managers, engage key stakeholders to facilitate process improvements. The organization also created four teaching modules to introduce front-line staff to Lean methodologies, which Craigie considers essential to driving culture change.

Garfield County Hospital District's PDSA Process Steps

- What is the problem?
- What is the root cause of the problem? Ask 'why?' five times.
- Brainstorm. What are some possible solutions?
- Plan:** What are we going to do?
- Do:** Test the idea.
- Study:** What happened? What did we learn?
- Act:** What are we going to do next?

Indeed, Lean is now an integral component of hospital operations. GCH improved documentation and coding, the nurse call system, and prescription ordering using Lean. To do so, Craigie developed a ten-step process for all large-scale improvement projects at GCH; this procedure convenes leaders from all functional areas in a 3–5 day rapid cycle improvement workshop. For smaller projects, departments use a Quick PDSA (Plan, Do, Study, Act) worksheet to apply the Lean methodologies.

Craigie encourages other CAHs to begin their own quality journey. "There's so many organizations that can benefit from using Lean tools that think they have to be an expert before they try it, and that's just not true," he says. "It's putting it into language that's relatable, engaging as much of the team as possible, and making a whole-sale commitment to it as an organization. If you really want to be successful, then it becomes part of your culture."

Dedicating Organizational Teams to Facilitate Lean Initiatives

At McCune-Brooks Regional Hospital (MBRH) in Carthage, Missouri, a project

team successfully used Lean Six Sigma to improve collections and reduce A/R days. Three years ago, MBRH opened a new facility and relied on organizational cash flow to meet financial obligations. After analysis by an external business partner revealed an increase in A/R days and lagging collections, CEO Robert Copeland identified Lean Six Sigma as a means to achieve desired results.

To build knowledge, MBRH leaders—including the CFO, director of health information, director of registration, director of quality improvement, and chief nursing officer—participated in an intensive training session led by the hospital's business partner; MBRH then extended this education to its management team, enabling them to help facilitate key process changes.

When assessment revealed MBRH was not enforcing the medical staff bylaws for obtaining physician signatures, Copeland designated a team to ensure timely chart completion. A group of nurses also worked to develop processes for recording IV start and stop times, which is required for reimbursement. "At one point, we had 17 teams, or around 30–45 people, working on projects," recalls Copeland. "We knew we had to [generate cash] to pay these bonds and we needed to get our days in A/R down, and we came together and did it." As a result, the hospital reduced A/R days from 60 to 44 and has sustained this improvement.

The leadership team also developed a new measurement system to track progress toward their collections goal. Data was entered into a box score, which showed monthly collection of gross charges for care. Initially, MBRH collected just over 40% of these charges. Through process improvements, the organization identified a software program to help monitor collections. By using Lean Six Sigma and integrating technology, Copeland and his team increased collections to 43% of charges within five months.

Although MBRH has achieved positive results through Lean Six Sigma, Copeland says limited staffing may be a concern for other CAHs. "The big barrier that critical access hospitals have is that we have a small leadership team, and our managers wear so many different

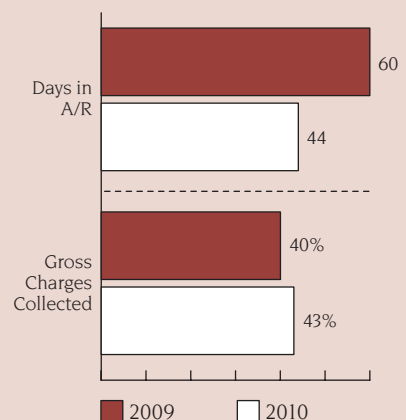
Rapid Cycle 10-Step Process at Garfield County Hospital

1. Choose priority process. What are the start and end points of the process? Who are the customers? What are their expectations?
2. Identify and choose priority problem.
3. Write problem statement. Identify what needs to be improved and by how much
4. Assign team members.
5. Physically walk and flowchart current process.
6. Create value-added timeline.
7. Identify ways to eliminate waste and process variation.
8. Flowchart new process steps.
9. Identify output and process measures.
10. Create an action plan. Identify what needs to be done, who is responsible, and when it should be completed

hats," he explains. "A department head in a smaller hospital not only has to manage people and their department with the resources budgeted to them, but also has to work as a clinician. So you probably have to have someone who will guide you through the process and educate you and the team."

By making organizational change a top priority and engaging staff in Lean Six Sigma improvement efforts, Garfield County Hospital and McCune-Brooks Regional Hospital have increased the efficiency of key processes. Other CAHs may consider exploring these quality improvement strategies as a means of effectively reducing waste and fostering collaboration among team members.

Improvements Achieved Through Lean Six Sigma at MBRH



Keeping Staff Engaged During Transitional Periods

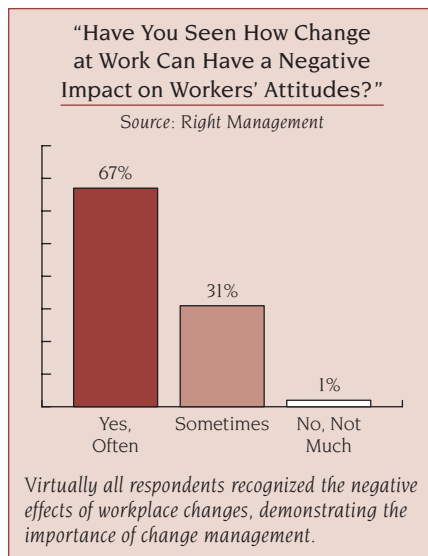
By nature, critical access hospitals often face greater resource and staff constraints than larger facilities. As a result, the uncertainty created by healthcare reform may have an even greater potential to impact CAH operations. In a setting where team members frequently perform multiple job functions, the prospect of large changes—and increased workloads as hospitals work to handle new requirements—can demotivate staff and disrupt revenue cycle efficiencies.

Overcoming Resistance with Communication

When confronted with change, many staff members' first instinct may be to resist; therefore, helping team members overcome hesitancy is crucial to maintaining productivity. While there are many reasons for resistance, lack of understanding about the need for changes often plays a large role or compounds the effect of other factors. Consequently, one effective strategy is to clearly communicate the rationale for changes.

Leaders at critical access facilities can use several communication vehicles:

- ☐ **Full staff meeting/forums**—ensures equitable distribution of information (all stakeholders simultaneously receive identical information) and promotes a two-way exchange
- ☐ **Targeted one-on-one discussions**—allow leaders to address individual concerns and secure buy-in from resistant team members
- ☐ **A kick-off luncheon**—can establish a positive association with changes and create unity
- ☐ **All-staff emails or memos**—may risk appearing impersonal, but can be used effectively throughout projects to reinforce positive messages and keep staff informed



By conveying upfront the necessity of action—and how changes will ultimately benefit the entire organization—leaders can demystify process improvements and even generate enthusiasm.

Getting Staff Involved at the Ground Level

While open communication can minimize apprehension, it is also important to engage staff in the project. Involving staff allows individuals to develop a sense of ownership for initiatives, which in turn motivates and empowers them. This step is vital within critical access facilities, where limited resources necessitate all available time and talent be leveraged for these efforts.

One approach is to **place staff in suitable project roles**. By giving staff a part in the project, they can become invested while gaining confidence in their abilities. Effective problem solvers can participate on a steering committee, setting a strategy for changes and monitoring progress. Likewise, relatable individuals can serve

as “project champions” who facilitate communication between front-line staff and leadership.

Another method is to **establish a suggestion box** during project planning. By placing one in a visible, accessible location, organizations can benefit from a valuable resource—the knowledge and experience of team members. Leaders can then openly incorporate suggestions into project plans to increase buy-in.

Incorporating Feedback Mechanisms

Once change has been enacted, organizations can arrange avenues for staff to communicate any lingering issues or concerns. While larger facilities sometimes develop “command centers” to track feedback, critical access hospitals can apply the same principle on a smaller scale to demonstrate staff insights are valued.

First, leaders can **increase the frequency of performance reviews** during changes. This approach gives leaders the chance to seek input and immediately respond to staff concerns. Organizations can also **conduct confidential surveys**, which allow team members to express their views without fear of reprisal and provide leaders with insight they may not otherwise receive. To maximize surveys' impact, leaders can publicly acknowledge common issues and inform staff of steps being taken toward resolution.

Change in the workplace can generate negativity and resistance on the part of staff, threatening revenue cycle performance—an effect magnified by the small size of critical access hospitals. By employing the techniques above, leaders can increase staff productivity and satisfaction, supporting revenue cycle performance even during transitions. ☐



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